MDR: M4-02-2747-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $18,323.10, for dates of service 04/19/01 through 04/24/01.

   b. The request was received on 03/12/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/05/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/06/02. The response from the insurance carrier was received in the Division on 09/20/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Letter requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   The only position statement from the Requestor is from the Table of Disputed Services states: "Claim should have been paid at 75% as bill exceeds 40K."

2. Respondent:

"The requester billed the carrier $48,985.47 for this 5-day stay. Commission Rule 134.401 (C)(6)(A)(i) states that, 'To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000,… Rule 134.401 (c)(2) states that 'All inpatient services provide[sic] by an acute care hospital for medical and/or surgical admissions well[sic] be reimbursed using a service related per diem amount.' Rule 134.401 (b)(2)(A) indicates 'All hospitals shall bill their usual and customary charges…' Review of the requester's bill indicates the actual hospital admission charges were below the $40,000 threshold following an audit of carve-out items. Using the per diem rate of $1118.00 for a 5-day admission, the carrier reimbursed the requester $5590.00.

2. Further review of the bill revealed an additional charges[sic] for the implants. In accordance with Rule 134.401 (c)(4)(A), the carrier reimbursed the implantables at cost plus 10% for a total of $12,826.00. It is worth noting that the charges for the constituted[sic] a significant portion of the total bill.
In other words, the markup on the implants equated to an increase of well in excess of 10%,rather than the increase of 10% indicated by Rule 134.401 (c)(4)(A).
In other words, it appears the implants serve the purpose to drive the total cost of the hospital stay over the stop-loss threshold…

In the instant case the cost calculation is based on the requester's charges. In other words, the requester's charges are the foundation from which to base a calculation of how much reimbursement is appropriate. The problem with this is that the *requester determines its own charges.* Given the problems referenced by the Commission in verifying costs in a cost-based system, a hospital could conceivably affect its level of payment without its costs being verified. And since ultimate reimbursement is dependent on costs there would be little incentive for the hospital to contain or control medical costs. Such problems were enough for the Commission to reject cost-based models of reimbursement as a valid methodology in determining payment for hospitals.

3. Section 413.011 (b) of the Labor Code states in part that guidelines for medical services must be fair and reasonable and designed to achieve effective medical cost control. Payment to the requester based on stop-loss methodology when the stop-loss threshold was bridged because of an unsubstantiated markup increase in the implantables, for unknown reasons, is not fair to the carrier or the policy-holder, is not reasonable, and is inconsistent with effective medical cost control. To pay the requester a stop-loss payment violates this section of the Labor Code. As such the Carrier cannot authorize additional payment for the disputed services."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 04/19/01 through 04/24/01.

2. The Provider billed the Carrier $48,985.47 for the dates of service 04/19/01 through 04/24/01.

3. The Carrier made a total reimbursement of $18,416.00 for the dates of service 04/19/01 through 04/24/01.

4. The amount left in dispute is $18,323.10.

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $48,985.47. Per Rule 134.401 (c)(6)(A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), those not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. The Carrier denied "Hospital Services" as "F-REIMBURSED IN ACCORDANCE WITH THE TEXAS HOSPITAL INPATIENT FEE GUIDELINE."

According to TWCC Rule 413.011(d):
"Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The provider has submitted two purchase orders that indicate evidence of the cost of the implants. The total indicated is $1,730.00 for one order and $9,930.00 for the other. The total of these two orders is $11,660.00. The provider indicates on the submitted UB-92 a total charge of $30,308.00 for the total cost of the implants. This suggests a 250% increase in the cost of the implants and makes the total charges a stop-loss dispute. The stop-loss total charges are $48,985.47. If you deduct $30,308.00 from the total billed charges ($48,985.47) this would make the charges $18,677.47. This would then make the medical dispute a per diem methodology and the costs of the implants would then be cost

plus 10% according to Rule 134.401(c)(4). This would equal an amount of **$12,826.00** ($11,660.00 x 10% = $1,166.00 plus $11,660.00 = $12,826.00.) The total billed charges for the entire stay, based on the per diem rate would be $5,590.00 (5 day stay x $1,118.00 Hospital charges) + $12,826.00 (Implantables) = $18,416.00 for the hospital stay.

Based on the information provided by the requestor, it would not appear that effective cost control has been achieved by a 250% mark-up on the implantables. Therefore, this dispute becomes a per diem amount and additional reimbursement **is not** recommended.

The above Findings and Decision are hereby issued this 9th day of October 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb